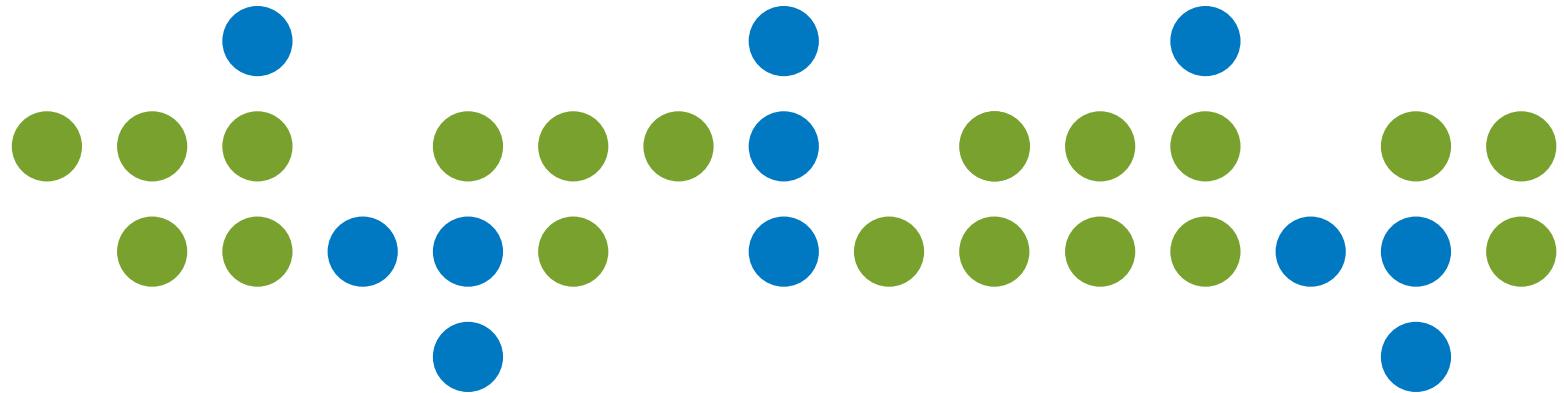




Robert Wood Johnson Foundation

The Road to Reform



[President's Message](#) from the 2008
Robert Wood Johnson Foundation
Annual Report

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America finally belongs to the 21st century. It is a moment of great challenge and opportunity. Our new president and Congress, along with public and private leaders all across the country and around the world, are grappling with economic, health, environmental, energy and security threats more immediate and frightening than most of us have ever known. What our leaders choose to do and what we ask them to do, or not do, will affect every aspect of our lives.



The American people expect improving health and health care to be among the priorities at the top of the national agenda. Polling every year since 2000 consistently registers a strong and unwavering public concern over the adequacy, cost, safety and fairness of health care financing and delivery. Not surprisingly, the people know what they are talking about. They take health care's measure each time they see their doctor, go to the hospital, pick up a prescription at the pharmacy, pay an insurance premium.

Patients and their families, employers, leading thinkers, policy-makers, researchers and health care providers all know that the system is not working. Yet many people still believe that Americans receive the best health care in the world. It is true that American medicine's technology is unsurpassed. But we pay more for the quality care we receive and we experience poorer patient outcomes than most other developed countries.

For longer than most of us have been alive, most serious attempts at systems change and quality improvement have fallen short. Perhaps that's because we have focused too much on isolating symptoms as stand-alone problems to be treated individually and incrementally. We realize that the confounding array of separate symptoms actually are a tightly bound interdependent complex system that resists division. Only recently, aided by sophisticated data collection and analysis, are we able to better understand and describe the interactions.

The most apparent symptoms include:

- Tens of millions are uninsured or underinsured.
- Variations in quality, safety, performance, and treatment are endemic.
- Avoidable medical and hospital errors kill thousands each year.
- Access to care is declining, uneven and unfair.
- Racial and ethnic disparities in health and health care delivery are pervasive.
- Adult and childhood obesity are epidemic.
- Prevention is overlooked and mental health discounted.
- Public health suffers from years of political neglect.
- Spending trends are unsustainable.
- Resources flood specialty care; resources drought afflicts primary chronic care.
- Demands of process and profit marginalize patients.

If any consensus is common among knowledgeable health and public policy experts it is this: Our health is part of a broader, complex and systemic problem. What to do about it is what this report is all about.

Much of the political discussion around health and health system reform is abstract, focusing on an often fuzzy big picture. Health and health care, however, are more down-to-earth, involving real people living real lives in the real world. I know this because I've seen medicine, health care and health policy through almost every facet of the prism. But there is seeing and there is "seeing."

My early days training in Boston hospitals were typical of medical residents everywhere. We worked 36 hours on, 12 hours off, surviving on vending machine snacks and gallons of coffee. The attending physicians were intimidating, the fatigue excruciating.

The procession of patients was never-ending. At each encounter the person was unique in history, symptoms and treatment. We worked fast: examine, diagnose, treat, next please. Total immersion in the minutia of medicine. That was it. I've never learned so much so fast that's stuck so long. It was one of the great experiences of my life.

Only after treating thousands of patients presenting across the spectrum of human malady and disease did the connections become clear to me: In our human ecology, the health of one person affects the health of all, and vice versa.

My awakening began, as it has so often for many health care providers, with a single patient. I'm not sure she even knew her real name. I do know she was

homeless and helpless and even though she was a military veteran we were unable to give her the level of care she needed.

She appeared very late on a winter night at the admitting station on the first floor of the old West Roxbury VA medical center, bringing the cold in with her. My guess is she came to us out of the woods that separates Roxbury from the Charles River and Cow Island Pond.

Her feet were swollen and covered by flimsy house shoes. Painful leg ulcers made it difficult for her to walk. Her medical chart was very thick; she'd been to the VA many times before. We did what they always did for her: A good tidying-up, antibiotics and a place to rest.

The next morning we had to let her go. Though I never saw her again, I've never forgotten my sadness and frustration that, apart from a few hours in a warm bed, some medicine and a decent meal, the system was not equipped to protect our patient from the harshness of her reality outside the hospital.

She limped back into the same problems she had before: no home, far too little nutritious food, inadequate clothing, no one to care for her, no social network to come to her aid. She was a vet with health coverage, but medical care alone was no match against the enormity of the social factors destroying her health and almost certainly shortening her life.

They didn't teach us in med school how to connect the dots between health, health care, community prevention programs, and a continuum of services that allow people to

enjoy healthy lives. Like many of my medical colleagues, we learned it the hard way, by going up against conditions controlling a patient's health and coming away wanting.

Comprehending the linkage between the health of a single individual and the macro factors affecting all of society radically altered my understanding and practice of medicine, shaped my appreciation of health and economic policy as powerful tools for change, and sharpened my vision of this Foundation's role in helping guide the country to better health and meaningful health system reform.

RWJF's efforts to improve health and health care for years ran along parallel tracks. Now we are merging the tracks. After years of research, trial, error and trying again, we are able to put in the hands of America's decision-makers a detailed picture of:

1 The causes of health care's chronic failure to deliver higher-quality care, better patient outcomes and higher value.

2 The toxic social, economic and cultural factors that can determine the status of our health more than our engagement with the health care system itself.

This is new. The earnest efforts of political, business and health system leaders to improve health and health care have been stymied for decades because the true causes and real cures remained hidden and mysterious. The veil, however, at long last is lifting; the mysteries solved.

We see four fundamental factors at play:

1

ONCE PUZZLING RIDDLES of social and economic determinants of health no longer baffle us thanks to years of research and data gathering. We know the nature of health and health care depend so strongly on education, income level, race, geography and residence that the condition of any one depends upon the condition of all others.

2

NEW KNOWLEDGE IS RE-ENGINEERING health care's systems, driving how we measure the performance of doctors, hospitals, and health plans and reward their results, connect quality to patient outcomes, make performance information available to the public, redirect resources, and overcome regional and racial disparities in treatment and in health.

3

KNOWLEDGE HAS POWER. For political and health care leadership, not knowing is no longer an excuse for inaction. New insight and information are filling in the old blanks. Evidence is replacing guesstimates.

4

IMPROVING HEALTH AND HEALTH CARE without busting the budget or carelessly rekindling ideological fires is doable economically *and* politically. One study, for example, estimates spending could be cut 30 percent if we stopped providing care that is not needed.¹

The question remains: How do America's leaders and policy-makers put the formula to work? The answer is clear: We translate our knowledge into action and we do it on a scale that hasn't been done before. Yes, the barriers are formidable. But our health care system is in critical condition. The time to act is now and the action begins—but should not end—with coverage.

Reformulate the four factors and we have what we did not have before: A formula for change. It works this way:

Formula for Change

(Knowledge + Understanding) (Motivation + Action) → Systems Change

Health insurance coverage for all² is the gateway reform to improving health and health care in America, especially in this era of extreme economic difficulty. Ten years ago the issue was a political pariah. Today it is among the most urgent national priorities. The reason: the economy.

The numbers help explain what changed. Late last summer, just days before the economic crisis reached critical mass, the Census Bureau released its routine annual report on income, poverty and health insurance coverage. Though the latest data, from 2007, already was a year old, it laid down the metrics of a chronic social and political malfunction that the economic meltdown compounds daily.

- **15.3 percent** of the population—45.7 million people—are uninsured,³ more than the combined population of 24 states and the District of Columbia.⁴
- More than **80 percent** are in working families, and that's before hundreds of thousands began potentially losing coverage as their employers downsized, cut back or shut down.⁵
- Minorities are hardest hit: **19.5 percent** of all African Americans and 32.1 percent of all Hispanics are uninsured.⁶
- At least **8.1 million** children, are without coverage, including nearly **18 percent** of all kids living in poverty.⁷

The human toll is awful. The Institute of Medicine reported in 2004 that someone in America dies every 24 minutes because they are uninsured and cannot get the medical care they need when they need it. They concluded that this leads to 18,000 unnecessary deaths each year.⁸ Subsequent studies point to even higher numbers.

We already know that those living without coverage receive less care than the insured and experience poorer outcomes. For instance:⁹

- When uninsured kids get sick, they tend to stay sick. They are twice as likely as insured kids to miss out on needed care including doctor visits and checkups.
- Adults lacking coverage are less likely to receive recommended preventive and screening services than insured adults.
- Uninsured pregnant women use far fewer prenatal services than publicly or privately insured pregnant women; their rate of unmet needs is more than twice that of insured women.
- Uninsured adults with chronic conditions such as diabetes or cardiovascular disease receive fewer professionally recommended services and experience worse health outcomes than insured patients with the same illnesses.

The IOM explained that the lack of coverage not only harms the uninsured individual, it “has implications for the entire family of the uninsured person and the community in which he or she lives, and economic costs to society nationally.”¹⁰

In a prescient conclusion, the IOM predicted that the situation “is expected to worsen in the foreseeable future because of federal and state budget constraints limiting public coverage programs, increasing costs of health care and insurance premiums, and continuing high rates of unemployment.”¹¹ They were correct; the near-term future is bleak.

The Kaiser Commission on Medicaid and the Uninsured reports that for every 1 percent increase in unemployment, another 1.1 million people join the ranks of the uninsured.¹²

Given that, consider this: In the few months it took the Census Bureau to collect and analyze its most recent data, the national unemployment rate shot up from 3.5 percent to 6.5 percent,¹³ potentially leaving at least 3.3 million more people without coverage.

Kaiser's model suggests a drop this big in the workforce will trigger (a) an estimated loss in tax revenues of between 12 and 16 percent, and (b) a hit on already-strapped state Medicaid programs that probably will exceed \$2 billion this year. The consequences ripple outward and upward through families, hometowns and across the country. Public and private America spent \$2.4 trillion on health care in 2008. On a macro level, that is nearly 17 percent of our entire economy; it's expected to hit 20 percent by the time today's fifth graders graduate from high school. On a more micro level, total yearly health care spending works out to about \$7,900 for each adult or child—about \$32,000 for a family of four.¹⁴

About two-thirds of all Americans are covered by employer provided health care insurance. Premiums for a typical family averaged \$12,680 in 2008, nearly 30 percent more than in 2004 and about 120 percent higher than a decade ago.¹⁵ The cost of similar coverage packages vary wildly, swinging 40 percent or more across employee groups and employers. The one constant is that employers and families cannot keep up with the pace of the perennial rate hikes.

The strain on small businesses is particularly hard. Health insurance costs for small firms have increased 129 percent over the last eight years. As a result, fewer than half of the smallest businesses—those with three to nine workers—no longer offer health benefits. For the employees of those that still do, premiums for family coverage have increased 78 percent, while wages, adjusted for inflation, rose only 2 percent.¹⁶

Consequently, last year nearly 1 of every 5 Americans had trouble paying medical bills.¹⁷ And the Gallup Poll reported that 1 of every 4 of us put off needed medical treatment because it is too expensive.¹⁸ For instance, 25 percent of all cancer patients or their families reportedly use up all or most of their savings to pay for treatment. After diagnosis, 1 in 10 are denied health coverage; 10 percent are not able to pay for food, heat and housing.¹⁹

No wonder the provision of health care in our society is as much an economic as a social issue. They are so inseparable that expenditures, revenues, profits and losses are measured with the same intense anxiety I feel when monitoring a diseased patient's vital signs. The similarities are striking. When one is well, the other is likely to be well, too, and vice versa.

A healthy workforce and economy depend so strongly on one another that the economic-health connection is particularly strained when the economy is weak. When the economy stumbles, workers lose jobs and coverage all at once, setting off a high-magnitude vicious cycle. Uninsured or underinsured workers still on the job are sicker, less productive and miss work

more often. The health status of the entire community is imperiled. At the same time, poor quality, uneven and wasteful health care rob the system of dollars and services needed to pay for expanded access and coverage. Without intervention, the cycle is self-perpetuating.

In other words, we cannot fix the economy without also fixing health care and improving health. The interdependence is so strong it resists separation—and it should. The trick is to see the linkage for what it is and to construct strategies and solutions accordingly.

This is perhaps one of the most profound truths to emerge from RWJF's 36 years of asking questions and finding answers about health, health care and the economy. Since we opened our doors in 1972, we have been supporting research and funding demonstration programs to help inform every major effort to secure universal health coverage. Much of the time it was a lonely struggle. When we launched our "Cover the Uninsured" campaign nearly 10 years ago, the issue didn't register as more than a faint blip on Washington's radar screen. By 2004, however, coverage was firmly established as one of the most important national issues. More recently, in polling at the time of the last election, the public ranked the economy and health care *together* as the two most important matters for government to address.

Our experience and the evidence convince us that health care coverage for everyone is an essential step to broader reforms and improvements. To lead the way, we asked a team of our own best experts to develop a concise, clear set of coverage principles policy-makers can follow. This is what they are:

RWJF Coverage Principles

Our commitment to achieving health insurance coverage for all Americans is based on the following basic concepts:

GOOD HEALTH IS NECESSARY for all Americans to participate fully in society and a healthy population is vital to the productivity and economic and social well-being of our nation.

HEALTH CARE IS CRITICAL to good health and should be available to all regardless of race/ethnicity, age, gender, geography or income.

HEALTH INSURANCE COVERAGE¹ IS ESSENTIAL for access to necessary and appropriate health care and should be available to all Americans.

Therefore, we believe that:

HEALTH INSURANCE COVERAGE SHOULD BE AFFORDABLE. Individuals should contribute to the cost of their care; however, the cost of health insurance and the out-of-pocket costs incurred in accessing care should not force individuals to choose between health care and other basic necessities of life.

HEALTH INSURANCE COVERAGE SHOULD INCLUDE NECESSARY, appropriate and effective health care services.

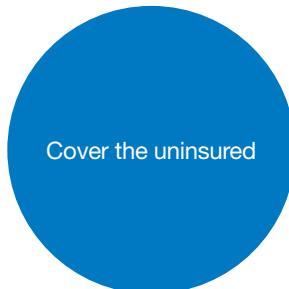
HEALTH INSURANCE COVERAGE SHOULD BE CONTINUOUS and portable, bridging life span, employment and geographic relocation.

HEALTH INSURANCE COVERAGE SHOULD PROMOTE HIGH-QUALITY and cost-effective health care.

HEALTH INSURANCE COVERAGE SHOULD BE BASED ON SHARED RESPONSIBILITIES between the public and private sectors and individuals. These responsibilities include the oversight, management and financing of the health care system.

It is not our role as a philanthropy to suggest precisely how lawmakers act upon these principles. But it is our job to see that critical matters like coverage are on the political agenda and to guide the national discussion toward common ground, common agreement and common action. We believe our "Principles for Health Care Coverage" serve this purpose.

But covering the uninsured alone will not solve what's ailing the health care system. We most strongly urge our leaders to consider coverage as part of a wider prescription package that would, for the first time, address the full continuum of interconnected factors linking both health and health care. This is where our Formula for Change will deliver results, so long as decision-makers take a comprehensive approach that includes the following:



COVER THE UNINSURED. RWJF's principles for coverage are the framework. The price we'll pay for not acting will be extreme. Economic recovery will falter if the health of millions of people and their communities is destabilized further. The damage to individual and population health, the demand on the health care system, and the drain of public and private resources quickly will become unsustainable.



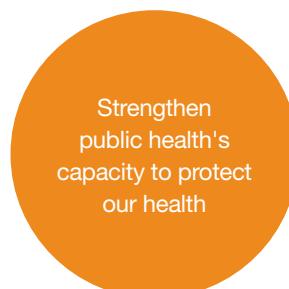
IMPROVE THE QUALITY, VALUE AND EQUALITY OF HEALTH CARE. Americans pay more for health care and receive poorer health outcomes than people living in all of the world's other developed nations. Disparities of race, ethnicity, residence, education and income are as universal as coverage is not. It is bad public, fiscal and medical policy to cover the uninsured without also securing for them better quality care that is reliable, safe and fair and provided by professionals and institutions that are publicly accountable for performance and cost.



BRING DOWN SPENDING (YES, IT CAN BE DONE). First, ask what can we spend, rather than what does it cost. Then ask how to make health care more affordable. The short-term answer is to develop new business models based on value-added improvements to health and not simply "sick" services rendered. The longer-term answer is to reduce the demand for care by helping people lead healthier lives.



PREVENT DISEASE AND PROMOTE HEALTHIER LIFESTYLES. Healthy families and communities are basic to economic recovery. Our aim should be to keep as many people healthy and out of the system as possible. Strategic investment in disease prevention and population health saves lives, strengthens families and the workforce, and reduces health care spending. We know from prior national campaigns to stop smoking and get people to buckle up that society-wide behavior change can work.



STRENGTHEN PUBLIC HEALTH'S CAPACITY TO PROTECT OUR HEALTH. Public health is America's first line of defense against disease and disaster that makes health promotion and disease prevention work. Yet, public health historically is under-resourced, has few champions, an infrastructure that's too fragile, and functions so far out of the public spotlight that no one pays attention until after it is needed. No sector so critical to the health and security of our people is so casually neglected so often by policy and lawmakers.



ADDRESS THE SOCIAL DETERMINANTS OF HEALTH. Treating illness one patient at a time does not improve the health of entire populations or communities. Where we live and work, buy groceries, go to school, who we know, what we earn all shape our behavior and health. Improving non-clinical social forces affecting health—housing, education, transportation, the economy—may be our biggest challenge of all. This is heavy lifting for the long haul. It will take a lifetime to make a difference, but it must be done in our lifetime.

This would be my treatment plan were I treating the health and health care systems as a very sick patient. My treatment plan would call for long-lasting, curative care that does not depend on quick-fixes, temporary bandages, blow-out rescues, bailouts or inflective re-dos. Nothing here is temporary, stop-gap or cosmetic.

We can do this now and do it well if we have the political will, the support of an informed and aroused public, the best and healthiest interests of the public as the priority, and we cultivate and sustain a climate for common action that transcends partisan politics.

Some regions exploit high intensity resources to their fullest to treat sick patients—more hospital stays, doctor visits, tests, imaging, the higher the technology the better. Other regions deliver better value and achieve the same or better results by treating similarly ill patients with far fewer resources and a lower volume of services. But it is the high volume providers who receive the highest reimbursements based solely on services rendered. The price tag is huge: Researchers estimate that a whopping 30 percent of health care spending—nearly \$800 billion a year²⁰—pays for inflated services regardless of results.

The one outcome that matters most to the American people is what improves their health and their access to affordable health care when they need it. This isn't post partisan; it is above partisan. Underpinning everything is data that reveals both problems and solutions.

Data is neutral. What it tells us is not.

Once aggregated and analyzed, data converts into a multi-dimensional digital print of health care as it really is. All it takes is a sampling to get the larger picture. It's not pretty. Take the inefficiency that seems hard-wired into the U.S health care system. When we compare what we spend across geographic regions to what we get, it is hard to believe we are all contained within a common border.

The *Dartmouth Atlas of Health Care*, which we have supported for more than 15 years, is the gold standard of applied health care research. The *Atlas* maps health care's evolving terrain in excruciating detail, plotting out revealing details of health care practice and delivery and the quality of care. The *Atlas* dispels old misconceptions and redefines our understanding of what really happens with health care. We now know that:

- More care is not necessarily better care.
- Racial and ethnic differences in care are ubiquitous and dangerous.
- The distribution of health itself varies widely across America.
- Life spans of different groups vary across different regions.²¹

For a stunningly different depiction of America's health, go online to *PLoS Medicine* (<http://medicine.plosjournals.org>) and search "Eight Americas."²² You'll find maps of the United States with all 3,441 counties, each broken into units color-coded in reds, pinks, violets and purples. These are the colors of life and death, each hue representing a variation of health status and longevity. The differences are so varied the colors splash across entire spectrums of the red and violet color wheels. Mix the bubbly colors with neutral data points about mortality rates, longevity, race, residence, income, population density and health insurance, and up pops the dramatic geography of the social and economic determinants of life spans among different groups of Americans.

The maps are the creation of Christopher Murray and his population policy colleagues at the Harvard Initiative for Global Health. They graphically plotted the role played in health inequalities by specific diseases and injuries; by risk factors like tobacco, alcohol, and obesity; and by county-by-county variations in access to effective health care.

Their findings read like clues in a high-stakes board game. Striking examples include:

● **NATIVE AMERICAN MEN** in South Dakota die, on average, at age 58 if they live near the reservation; they generally survive into their 70s when they live elsewhere.

● **YOUNG AND MIDDLE-AGED BLACKS** in dangerous urban areas have mortality risks as poor as in war-torn Chechnya or parts of sub-Saharan Africa. In the worst-off urban areas, it's not guns, drugs or HIV that cause the most early deaths; it's alcohol, tobacco, obesity and diabetes.

● **MORE THAN 200 MILLION SO-CALLED "MIDDLE AMERICANS"** have a per capita income of about \$25,000 and an average life expectancy of 78. But the 17 million Whites in Appalachia and the Mississippi Valley, earn about \$8,000 less and die three years earlier.

While the variations are gripping and clear, their causes are not so obvious. The entanglement of disease, race, geography, economics and behavior is terrifically complex and will not lessen until policy and funding decisions match the realities of daily life of people in communities with poor health.

The answers data provide often lead to new questions.

Think of it this way: Do we treat one obese child at a time or do we also eliminate junk foods and sugary drinks from schools, emphasize more and better phys ed and less screen-time, regulate deceptive marketing of unhealthy foods to kids, build sidewalks for safe walking and playgrounds for safe playing?

Do we react after the fact to medical errors one hospital at a time or do we model, test and widely replicate evidence-based system changes that will save lives in all hospitals?

Do we accept racial and ethnic disparities in health care and health outcomes as inevitable aspects of American society, or do we search out community-deep causes like poor housing with lead paint, lead pipes and mold; densely-populated low-income neighborhoods without public transportation to the nearest hospital four miles away; young, inexperienced mothers with no one they trust to teach them the rudiments of pre- and post-natal care—in their own language, if needed?

Do we wait for chronic medical conditions like diabetes, asthma and high blood pressure to become acute before we treat, or do doctors and hospitals work with patients to proactively manage their diseases and pre-empt crises before they occur?

The U.S. Department of Health and Human Services has had it right for some time. This is what they have to say about social determinants of health and health disparities:

“ . . . communities, states, and national organizations will need to take a multidisciplinary approach to achieving health equity—an approach that involves improving health, education, housing, labor, justice, transportation, agriculture, and the environment, as well as data collection itself.”²³

If Hippocrates were alive today, I would want him to be an RWJF partner. His advice was so solid we still rely on it 2,400 years later. He understood that an ounce of prevention really is worth a pound of cure, or, as he put it:

“ The function of protecting and developing health must rank even above that of restoring it when it is impaired.”

What antiquity's fabled family doctor *didn't* tell us was how to convince politicians and policy-makers that it makes good fiscal sense to invest in community prevention and healthy living programs. Instead, we are stuck with a system accustomed to paying a fortune on care once you are ill but only a pittance to keep you healthy in the first place. This clash between the economics of health care and the realities of our people's health is serious.

We spend almost **95-cents** of every health care dollar on “acute care” for people who already are sick; most of them suffer from one or more chronic illnesses. Only half of these patients will receive the recommended care; the other half get care that may not help them at all. Meanwhile, **only about 2-cents** of that same health care dollar goes to prevent illness and keep people away from the health care system altogether.

In fact, the system has been so absorbed for so long with providing profitable “sick care,” it no longer notices the absurd pathology of the 95-to-2 allocation. And with hospitals and providers locked in a highly-competitive medical arms race to sell consumers the most costly, profit-boosting new-tech services, the health care sector has little inducement to change. It gets hard to tell the difference between special interest and self interest. The public interest, however, seems to be taking a beating.

Just as devastating are the paltry economics of the public health sector that Americans assume is fully geared-up to protect our health, prevent disease and help us lead healthier lives. We thought for sure public health would experience a renaissance after Katrina alerted all of America to public health’s essential role in the health security of every community. Inexplicably, though, public health funding at every level has been reduced radically each year since the storm. The annual shortfall is enormous—some \$20 billion a year—according to our partner, Trust for America’s Health (TFAH).²⁴

With TFAH and other RWJF grantees, we are building a national population health evidence base for disease prevention and improvements in public health programs. Our aim is to show national, state and local political leadership that when they make strategic near-term investments in effective, evidence-based disease prevention programs they will spare millions of people from serious illness and save billions of public and private dollars in the long-term. As always, money talks loudest in health care. This time, however, we want it speaking our language of change.

In a significant yet-to-be-published study which we recently funded, health policy experts Glen Mays and Sharla Smith at the University of Arkansas took the most comprehensive look yet at the effect of local public health spending on population health. They analyzed data from 2,900 local and state public health agencies and matched what communities spend on public health with rates of mortality among infants and deaths due to cardiovascular disease, diabetes and cancer.

Then they asked "Does more money matter?" The evidence conclusively answered, "Yes!" For each 10 percent increase in public health spending, mortality rates fell as much as 6.9 percent.

Mays and Smith also determined that funding public health is a faster and cheaper way to lower mortality rates than beefing up local medical resources. For instance, when an average community increases its public health spending by only 10 percent—roughly \$300,000—the deaths from heart disease decrease 3.2 percent.

To compute what this means for real people, I randomly Googled "cardiovascular mortality by county" and ended up in Larimer County, Colorado. Here, along the Front Range of the Rocky Mountains, county health officials reported 451 county residents died of cardiovascular disease in 2006. Under the Mays-Smith model, a 10 percent increase in public health funding would have saved 9 of those lives.

To get the same outcome without relying on public health would take 14 new primary care physicians for every 10,000 in population. If you figure that a typical new family doctor makes about \$176,000 a year—that's \$2.5 million in new spending for enough doctors to achieve the same outcomes the community could realize by spending only \$300,000 on programs to improve the health of the public.

A separate study by TFAH took an in-depth look at the return on investment (ROI) in disease prevention. They documented that even a small investment in community prevention will produce substantial savings in overall health care costs.²⁵

Analysis by the New York Academy of Medicine and an outside panel of experts found that an investment of \$10 annually per person in local programs to increase physical activity, improve nutrition and prevent smoking could save the country more than \$16 billion within five years.

Drilling deeper into one community's data, the evidence showed that spending \$10 per person annually on prevention programs in less than five years produced 5 percent reductions in type 2 diabetes, high blood pressure, heart and kidney disease and stroke. According to the experts, the ROI works out to savings of \$5.60 for every \$1 invested. Projected savings include \$5 billion for Medicare; \$1.9 billion for Medicaid; and \$9 billion for private payers. The financial math is compelling, the human math is beyond calculation, and the immediate need overwhelming.

Late last year TFAH followed up its ROI analysis with a national health and prevention strategy to modernize public health's capacity to prevent disease, prepare for disasters and reduce health care costs. The top recommendation went straight to that 95-to-2 funding paradox and public health's current \$20-billion deficit. TFAH called for a stable, reliable funding stream for public health activities across local, state and federal levels. TFAH also proposed strengthening the public health workforce and an emergency health benefit for the uninsured and under-insured during major disasters and disease outbreaks.²⁶

The new research in disease

prevention further exposes an expensive and aimless sub-system of chronic care that's addicted to an uninventive, even obstructive payment system that rewards oversupply of services and volume of care whether they work or not. This creaky carryover from the other side of our epochal divide locks down poor quality, inhibits innovation, and avoids change to a degree we do not see in other major sectors of our social and economic life. According to the Centers for Disease Control and Prevention,²⁷ almost half of all Americans live with at least one chronic condition. The cost of their care consumes 75 percent of everything spent on health care every year. For example, diabetes—\$174 billion; arthritis—\$81 billion; heart disease and stroke—\$448 billion; obesity—as high as \$200 billion annually.

Not all of it is necessary. As many as 4.4 million hospital stays (median cost in 2006—almost \$13,000 a stay) could be avoided by better managing chronic conditions, providing better care *outside* the hospital, improving access to effective treatment, and helping patients adopt healthier behaviors.²⁸

The old way of doing business profited when people were sicker longer, but that model hurts everyone. Here's where a fiscal revolution really is required to reallocate dollars away from business-as-usual poor-quality care. Instead, we should funnel funding to long-term health improving cost reducers like universal coverage, expanded access, higher quality, payment reform and better management by patients of their own chronic conditions.

The old conventional wisdom holds that the problems are too big, too entrenched and too expensive to tackle right now; wait until we first fix the economy. The new conventional wisdom says waiting makes matters worse; the problems are too intricately interwoven to compartmentalize as stand-alone, next-in-line patients waiting to be treated one at a time.

When policy-makers get it right, they will realign private and public payment schemes to benefit quality performance over the volume of services. Finally, providers that successfully provide quality care and reduce excessive care will be rewarded, not penalized. This certainly makes good sense to most people. Mention it to your favorite doctor or hospital executive, though, and you'll discover they may find this notion of "quality improvement" to be revolutionary—and not necessarily welcome.

The “value gap” between what we spend on care and what we get in return is a fundamental cause of America’s joined health care and economic crises. We spend twice as much per person on health care than any other advanced nation in the world but don’t deliver the quality of care, patient outcomes, improvements in public health and longer life spans as do many other countries.

This indisputable and shocking fact is still little known to the American people, under-reported by the media, and generally ignored or discounted by many leaders—as if “this can’t be” is sufficient refutation of a perceived attack on American exceptionalism. But within the serious health policy, legislative, philanthropic, academic, think tank and provider community, reversing the decline in American health status and health care is the all-consuming priority. For insight and answers, we turned to some of the best thinkers in the field and friends of the Foundation.

KAREN DAVIS, my philanthropic colleague at the Commonwealth Fund, puts it this way: “The United States has been slow to learn from countries that have systematically adopted policies that curtail spending and enhance value.” She suggests a series of policy changes with “the potential to substantially bend the curve of projected health care spending” with estimated savings as high as \$1.5 trillion over a 10-year period.²⁹ Typical policy options and projected savings include:

- \$194 billion: Patient-centered medical homes for Medicare’s primary care patients.
- \$43 billion: Negotiated pharmaceutical prices.
- \$229 billion: Hospital/physician services bundled in a single episode-of-care payment.
- \$191 billion: Promoting public health and reducing obesity.

In addition, the Commonwealth Fund analysts predict that insuring all Americans will save another \$1.6 trillion when combined with initiatives to improve quality and performance.³⁰

DAVID EDDY at Archimedes, Inc., a RWJF grantee; Greg Pawlson, executive vice president of the National Committee for Quality Assurance; and a group of associates, reminded us how powerful existing data can be when it’s looked at in new ways with new tools. They demonstrated how the systematic use of national performance measures can improve health if they are used to drive health care delivery. The measures they used—called the Health Care Employer Data and Information Set (HEDIS)—track how performance improvements over time affect the morbidity and mortality of specific diseases. What Eddy’s group found when they analyzed HEDIS results for diabetes and cardiovascular disease from 1995 to 2005, is that the improvements translate into the prevention of nearly 1 million heart attacks, 800,000 strokes and 100,000 cases of end-stage renal disease. The HEDIS data makes the point: If we can measure quality, we can achieve it.³¹

JOHN WENNERBERG and his associates at the *Dartmouth Atlas*, meanwhile, estimate that paying only for care that is needed can save Medicare \$30 billion a year without negatively affecting health outcomes. The trick is to bring the high-cost and medium-cost Medicare regions inline with the more efficient, better value spending levels of the low-cost regions. Better yet, do this in the larger health care system and the experts believe the savings will be just as big.³²

PETER ORZAG, the new director of the Office of Management and Budget and former head of the Congressional Budget Office, building on Wennberg's work, takes it even further, concluding that Medicare spends at least \$700 billion a year on health care that does nothing to improve or affect patient status. His solution: Stop funding futile activities and improve health care by following evidence-based standards of best practice.³³

CLAYTON CHRISTENSEN at the Harvard Business School applies his popular concept of "disruptive innovation" to health care and comes up with the first breakthrough business model designed to make health care more affordable. This is exactly what advocates for the bottom line in both the public and private sectors have been waiting for. Christensen and Jason Hwang of the Innosight Institute shift the center of gravity in health care's business model from high-cost "solution shops"—doctors and hospitals—to a technology-based value-added model that achieves attractive operating margins by delivering high-quality services and high-demand products at a lower cost. A nurse practitioner rather than a physician, for example, follows a rules-based diagnostic test to verify common childhood strep throat, then writes a prescription to cure the infection. Christensen estimates that by adopting his "disruptive" value-added business model, hospitals and clinics can deliver care at prices 60 percent lower than the old-guard solution shops.³⁴

The hardest tests of our national character come when we are called upon every two or three generations to confront truly "tipping point" menaces to the health, security and well-being of our way of life. You can count the Republic's toughest tests on the fingers of one hand. Thankfully, the American people and our leaders have passed each trial by applying the lessons learned the last time around.

Back in the darkest moments of the 20th century, as our nation teetered between Great Depression and World War, American families were driven by fears and anxieties much like what we are living through today. In the first week of January, 1941, Franklin Delano Roosevelt, "thinking of our children and their children," went before Congress.³⁵ With his characteristic optimism and determination he reminded Americans what matters the most—the common good.

"There is nothing mysterious about the foundations of a healthy and strong democracy," he said, ticking off equality of opportunity, jobs, and security for those who need it. "The inner and abiding strength of our economic and political systems is dependent upon the degree to which they fulfill these expectations." It still is.

Amazingly, many of our expectations for health care remain unfulfilled, even after some 70 years of trying. Like then, millions are uninsured and without needed care, hospitals can be just as dangerous, the "haves" always have it and the "have-nots" do not, and what you get for what you're charged still seems out of whack.

RWJF Blueprint for Change



What *has* changed—and it's taken us oh so long—is that, as detailed in this report, now we know what to do and how to do it, so long as we follow the clear-cut, principled, evidence-driven blueprint set forth in this year's president's message:

- Cover the uninsured.
- Improve the quality, value and equality of health care.
- Bring down spending.
- Prevent disease and promote healthier lifestyles.
- Strengthen public health's capacity to protect our health.
- Address the social determinants of health.

In that same speech, FDR told us, "Since the beginning of our American history ... we have been engaged in change—in a perpetual peaceful revolution—a revolution which goes on steadily, quietly adjusting itself to changing conditions."

Thus, in this new century, history dares us to face up to the changing conditions of our generation's America and fix what is broken, discard what has failed, and accomplish what is needed and new.

I have tremendous hope that we can develop common sense solutions to our nation's crisis of health. I believe that we can continue to make great strides when it comes to disease—that we can catch it earlier, treat it better, and prevent it from starting in the first place. I believe that we

can increase the quality and equality in our health care system. And I believe that we can overcome the obstacles to better health facing our society. The tools are already on the table.

But to do all of that, we must connect what we know with what we do. There is no responsible reason for not acting. Accepting the status quo and doing nothing is not a viable alternative; the consequences of inaction are far too serious.

And above all else, we must remember that what matters most to Americans is knowing that they have the opportunity to lead healthy lives, that health care will be available when they need it, and that they get the best quality and value for what they spend on that care.

We can do this. One child at a time, one family at a time, one community at a time. We can do this, even if it means changing the world around us and changing ourselves in the process. The evidence is in, and the time to act is now.

Respectfully submitted,

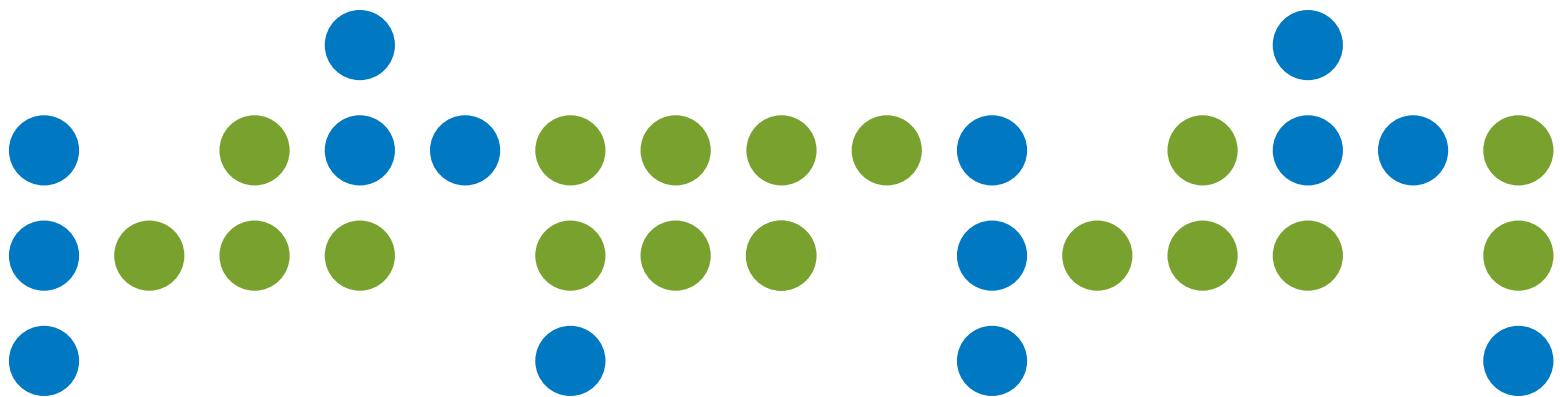
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Winter 2009